Syracuse Hearing Solutions 5639 W Genesee St Camillus, NY 13031
315-468-2985 / fax: 315-320-0245 / info@syracusehearing.com

Patient Information

Patient's Name _____ (First) (Initial) (Last)

Responsible Party (if patient is a child, Parent or Guardian) _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work** _____ **Mobile** _____ **Other** _____ **Primary:** ☐ H ☐ W ☐ M ☐ O

Date of Birth _____ **Sex** M F (circle) **Email** _____

Marital Status Married Single Other (circle) **Employment Status** FullTime PartTime None (circle) **Student Status** FullTime PartTime None (circle)

Referring Physician _____ **Primary Physician** _____

Is there a place/physician we can send a copy of your test results? _____

Emergency Contact _____ **How did you hear aboutus?** _____

How would you like to receive Appointment Notifications? ☐ Telephone ☐ Text ☐ Email ☐ None

Primary Insurance Information

(if patient is also the insured, enter 'SAME' for name & address) *(Office only): Insurance Card copy on file?* _____

Insured's Name _____ (First) (Initial) (Last)

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Patient Relation to Insured Self Spouse Child Other (circle) **Insured Date of Birth** _____ **Insured Sex** M F (circle)

Insured Employment Status FullTime PartTime None (circle) **Insured Employer** _____

Insurance Co. Name _____ **Subscriber ID Num** _____ **Group Num** _____

Other Insurance Information

(if patient is also the insured, enter 'SAME' for name & address) *(Office only): Insurance Card copy on file?* _____

Insured's Name _____ (First) (Initial) (Last)

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Patient Relation to Insured Self Spouse Child Other (circle) **Insured Date of Birth** _____ **Insured Sex** M F (circle)

Insured Employment Status FullTime PartTime None (circle) **Insured Employer** _____

Insurance Co. Name _____ **Subscriber ID Num** _____ **Group Num** _____

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed _____ **Date** _____

Syracuse Hearing Solutions-PATIENT HIPAA CONSENT FORM

Last revised December 06, 2019

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

1) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2) Obtaining payment from third party payers (e.g. my insurance company); The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Syracuse Hearing Solutions reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

My "protected health information" (“PHI”) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider’s use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative’s Authority

Syracuse Hearing Solutions
@ Preferred Audiology Care, LLC
5639 West Genesee Street
Camillus, NY 13031
Phone: 315-468-2985
Fax: 315-320-0245

Patient Name:_____

PERMISSION TO RELEASE RECORDS:

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us permission to send a copy to your physician(s), and/or any relevant parties that are listed below. This release will be in effect until we receive a written notice from you requesting we may no longer forward this information.

I authorize release of my records to the following:

Physician or Referring Agency: _____
This waiver authorizes Syracuse Hearing Solutions to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health information on my home/cell phone:__yes __ no

Leave a voice mail recording including my Personal Health information on my business phone:__yes __ no

Permit Syracuse Hearing Solutions to share personal health information with other health care providers, family members and/or school personnel as necessary to carry out my care:__yes __ no

PERMISSION TO OBTAIN RECORDS:

In order to provide you with the best service possible, we may be required to contact your physician, previous audiologist, hearing aid dispenser, or hearing aid manufacturer for information regarding your hearing, hearing aid information, warranty, etc. This release will be in effect until we receive a written notice from you requesting we no longer forward this information.

I authorize permission to obtain my records from the following:

PATIENT SIGNATURE or GUARDIAN SIGNATURE

_____ DATE_____

PRINT PATIENT NAME: _____

RELATIONSHIP TO PATIENT _____